LEGISLATIVE SERVICES AGENCY
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FISCAL IMPACT STATEMENT

LS 7088
BILL NUMBER: HB 1264

NOTE PREPARED: Jan 6, 2010
BILL AMENDED:

SUBJECT: Emergency Room Medicaid Reimbursement.

FIRST AUTHOR: Rep. Brown T
FIRST SPONSOR:

BILL STATUS: As Introduced

FUNDS AFFECTED: X GENERAL
X DEDICATED
X FEDERAL

IMPACT: State

Summary of Legislation: This bill specifies emergency department screening services requiring reimbursement under the Medicaid program.

Effective Date: July 1, 2010.

Explanation of State Expenditures: This bill would require OMPP and a Medicaid managed care organization (MCO) to pay 100% of the Medicaid fee-for-service reimbursement rates for certain screening exams provided by a physician in an emergency department. The bill would result in increased costs to the state to the extent that any increased risk-based managed care costs would be passed through to the state in the annually calculated and negotiated MCO capitated rates.

OMPP has reported that within the fee-for-service program, these physicians' claims are reimbursed. The fiscal impact of this provision will depend on MCO policy decisions and actions taken to control inappropriate use of emergency departments by their enrollees.

This bill defines the screening services by the Current Procedural Terminology (CPT) codes. Financially, this requirement would impact the three MCOs differently, depending on the contracted status of the emergency department physicians if the organization is currently paying screening fees to contracted providers or denying the claims in total. The fiscal impact of this provision will ultimately depend on actions taken by the individual MCOs to control inappropriate use of emergency departments by their enrollees.

Background Information:

The Medicaid managed care program operates under a federally approved waiver. The regulation waived is the recipient's freedom of choice. MCO recipients select or are assigned a primary care provider to give the individual a "medical care home". The primary care provider is then responsible for that recipient's preventative and routine care. Controlling the cost of inappropriate use of emergency room services is one of the methods that MCOs use to control costs within the network.

Any denied payments occur within the capitated managed care contracts. The denial of payment does not represent a direct savings or cost to the state since the state pays a capitated amount for each MCO member month regardless of the cost incurred by the MCO for the member's care. The bill would result in increased costs to the state to the extent that increased risk-based managed care costs, which must be actuarially determined, would be passed through to the state in the negotiated rates for the CY 2011 capitation rate. Any fiscal impact related to this bill would be anticipated to result in higher capitated rates for calendar years 2011 and 2012.

The Medicaid program is jointly funded by the state and federal governments. The state share of program expenditures is approximately 34%. Medicaid medical services are matched by the federal match rate (FMAP) in Indiana at approximately 66%. Administrative expenditures with certain exceptions are matched at the federal rate of 50%.

Explanation of State Revenues: See *Explanation of State Expenditures* regarding federal reimbursement in the Medicaid program.

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: FSSA, Office of Medicaid Policy and Planning.

Local Agencies Affected:

Information Sources:

Fiscal Analyst: Kathy Norris, 317-234-1360.